

Questionnaire No:

--	--	--	--	--	--	--	--	--

**TWELVE YEARS ON**



This questionnaire is for the study child's mother or person taking the role of mother. To answer simply tick the box which is most accurate in your opinion.

Changes are occurring around our study children all the time, both in the family and in life outside. Some questions we ask in this questionnaire are the same as those you have answered before. This is so that we can tell what changes there may be in your health and lifestyle.



If you do not want to answer a question or if it does not apply to you, put a line through it. There are no good or bad answers. Just tell us what is true for you.

**ALL ANSWERS ARE CONFIDENTIAL**

**Thank you for your help**

## **SECTION A: YOUR HEALTH**

A1. Which of the following would you say describes your health now?

fit and well	<div>1</div>
mostly well and healthy	<div>2</div>
often feel unwell	<div>3</div>
hardly ever feel well	<div>4</div>

A2. Have you had any of the following in the last 2 years (since your study child's 10th birthday)?

<b>In last 2 years:</b>	<b>Yes and consulted doctor</b>	<b>Yes but did not consult doctor</b>	<b>No</b> ↓
a) anxiety or 'nerves'	<div>1</div>	<div>2</div>	<div>3</div>
b) depression	<div>1</div>	<div>2</div>	<div>3</div>
c) headache or migraine	<div>1</div>	<div>2</div>	<div>3</div>
d) epilepsy	<div>1</div>	<div>2</div>	<div>3</div>
e) back pain, sciatica, slipped disc	<div>1</div>	<div>2</div>	<div>3</div>
f) indigestion	<div>1</div>	<div>2</div>	<div>3</div>
g) high blood pressure	<div>1</div>	<div>2</div>	<div>3</div>
h) cough or cold	<div>1</div>	<div>2</div>	<div>3</div>
i) diabetes	<div>1</div>	<div>2</div>	<div>3</div>
j) haemorrhoids/piles	<div>1</div>	<div>2</div>	<div>3</div>
k) schizophrenia	<div>1</div>	<div>2</div>	<div>3</div>
l) influenza	<div>1</div>	<div>2</div>	<div>3</div>

A2 cont.

	Yes and consulted doctor	Yes but did not consult doctor	No ↓
<b>In last 2 years:</b>			
m) alcohol problem	<div>1</div>	<div>2</div>	<div>3</div>
n) wheezing or asthma	<div>1</div>	<div>2</div>	<div>3</div>
o) bronchitis	<div>1</div>	<div>2</div>	<div>3</div>
p) stomach ulcer	<div>1</div>	<div>2</div>	<div>3</div>
q) eczema	<div>1</div>	<div>2</div>	<div>3</div>
r) psoriasis	<div>1</div>	<div>2</div>	<div>3</div>
s) arthritis	<div>1</div>	<div>2</div>	<div>3</div>
t) rheumatism	<div>1</div>	<div>2</div>	<div>3</div>
u) urinary infection	<div>1</div>	<div>2</div>	<div>3</div>
v) problems with your periods	<div>1</div>	<div>2</div>	<div>3</div>
w) problems with a pregnancy	<div>1</div>	<div>2</div>	<div>3</div>
x) syphilis	<div>1</div>	<div>2</div>	<div>3</div>
y) gonorrhoea	<div>1</div>	<div>2</div>	<div>3</div>
z) cancer (please state type)	<div>1</div>	<div>2</div>	<div>3</div>

.....

za) other problems (please tick and describe)	<div>1</div>	<div>2</div>
--	--------------	--------------

.....

A3. In the last 2 years how often have you taken the following?

In last 2 years:	Every day	Often	Sometimes	Not at all
a) antibiotics	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
b) aspirin	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
c) paracetamol	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
d) other painkillers	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>

A4. a) In the past year have you taken or used any homeopathic medicine(s) or remedies?

yes, often 

1

      yes, sometimes 

2

      no 

3

 → **If no, go to A5 below**

b) **If yes**, please describe the name(s) of the homeopathic medicine(s) and the reason for taking/using them:

Name:	Reason:
1. ....	.....
2. ....	.....
3. ....	.....
4. ....	.....
5. ....	.....

A5. Please list all the other drugs, medicines and ointments that you have taken or used **in the past month**:

What did you take:	About how many days did you take or use it?	How often per day?
1. ....	.....	.....
2. ....	.....	.....
3. ....	.....	.....
4. ....	.....	.....

	What did you take:	About how many days did you take or use it?	How often per day?
A5.	5. ....	.....	.....
	6. ....	.....	.....
	7. ....	.....	.....
	8. ....	.....	.....
	9. ....	.....	.....
	10. ....	.....	.....

**Check** Have you included the contraceptive pill, iron tablets, laxatives, skin creams, vitamins, sleeping tablets, aspirin, cough mixture, pain killers, herbal medicine, slimming pills?

A6. a) Since your study child's 9<sup>th</sup> birthday have you been admitted to hospital?

Yes

No  → If **no**, go to A7 on page 8

If **yes**,

b) how many times?

c) for how many different reasons?

**Reason for each hospital stay:**

**How long did you stay?**

d) .....   nights

e) .....   nights

f) .....   nights

g) .....   nights

h) .....   nights

↓  
Write 00 if you did not stay overnight

A7. In the past month, how often have you had any of the following:

In the past month:	Almost all the time	Sometimes	Not at all
a) backache	<div>1</div>	<div>2</div>	<div>3</div>
b) headache or migraine	<div>1</div>	<div>2</div>	<div>3</div>
c) urinary infection	<div>1</div>	<div>2</div>	<div>3</div>
d) nausea	<div>1</div>	<div>2</div>	<div>3</div>
e) vomiting	<div>1</div>	<div>2</div>	<div>3</div>
f) diarrhoea	<div>1</div>	<div>2</div>	<div>3</div>
g) haemorrhoids or piles	<div>1</div>	<div>2</div>	<div>3</div>
h) feeling weepy/tearful	<div>1</div>	<div>2</div>	<div>3</div>
i) feeling irritable	<div>1</div>	<div>2</div>	<div>3</div>
j) feeling exhausted	<div>1</div>	<div>2</div>	<div>3</div>
k) varicose veins	<div>1</div>	<div>2</div>	<div>3</div>
l) passing urine very often	<div>1</div>	<div>2</div>	<div>3</div>
m) problem holding urine when you jump, sneeze etc.	<div>1</div>	<div>2</div>	<div>3</div>
n) indigestion	<div>1</div>	<div>2</div>	<div>3</div>
o) feeling dizzy/fainting	<div>1</div>	<div>2</div>	<div>3</div>
p) flashing lights/spots before eyes	<div>1</div>	<div>2</div>	<div>3</div>
q) shoulder ache	<div>1</div>	<div>2</div>	<div>3</div>
r) tingling in hands/fingers	<div>1</div>	<div>2</div>	<div>3</div>
s) tingling in feet/toes	<div>1</div>	<div>2</div>	<div>3</div>
t) neck ache	<div>1</div>	<div>2</div>	<div>3</div>
u) feeling depressed	<div>1</div>	<div>2</div>	<div>3</div>

A7	Almost all the time	Sometimes	Not at all
<b>In the past month:</b>			
v) other problem (please tick and describe)	<div style="border: 1px solid red; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;">1</div>	<div style="border: 1px solid red; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;">2</div>	<div style="border: 1px solid red; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;">3</div>

.....

.....

A8. a) How often are you having sexual intercourse now?

not at all	<div style="border: 1px solid red; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;">1</div>
less than once a month	<div style="border: 1px solid red; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;">2</div>
1-3 times a month	<div style="border: 1px solid red; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;">3</div>
about once a week	<div style="border: 1px solid red; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;">4</div>
2-4 times a week	<div style="border: 1px solid red; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;">5</div>
5 or more times a week	<div style="border: 1px solid red; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;">6</div>

b) In general, do you enjoy it?

yes, very much	<div style="border: 1px solid red; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;">1</div>
yes, somewhat	<div style="border: 1px solid red; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;">2</div>
no, not a lot	<div style="border: 1px solid red; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;">3</div>
no, not at all	<div style="border: 1px solid red; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;">4</div>
no sex at the moment	<div style="border: 1px solid red; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;">5</div>

A9. a) Are you currently trying to get pregnant?

no

no, but intend to later

yes, we are trying

I am already pregnant

→ **If yes**, (i) for how long have you been trying?

months

→ **If yes**, (ii) how long were you trying before you became pregnant?

**now go to A10 on page 11**

months

**now go to A10 on page 11**

A9. b) What forms of contraception are you and your partner using now? (tick all that you have used in the past 3 months)

**Yes**

i) withdrawal

ii) the pill

iii) IUCD/coil

iv) condom/sheath

v) calendar/rhythm method

vi) diaphragm/cap

vii) spermicide

viii) I am no longer fertile (have been sterilised, etc.)

ix) my partner has been sterilised

x) none

xi) other (please describe)



.....

A10. Please describe your most recent periods:

	<b>Very</b>	<b>Moderately</b>	<b>Mildly</b>	<b>Not at all</b>	<b>No periods</b>	
a) how heavy are your periods?	<div><div>1</div></div>	<div><div>2</div></div>	<div><div>3</div></div>	<div><div>4</div></div>	<div><div>7</div></div>	→ go to A11 on page 12
b) how painful are your periods?	<div><div>1</div></div>	<div><div>2</div></div>	<div><div>3</div></div>	<div><div>4</div></div>		
c) are your periods irregular?	<div><div>1</div></div>	<div><div>2</div></div>	<div><div>3</div></div>	<div><div>4</div></div>		

d) how many days does bleeding usually last?  days

e) Do you generally find in the days before or during your periods that you have particular problems (please tick all that apply)?

	<b>Yes before</b>	<b>Yes during</b>
i) Very fatigued	<div><div>1</div></div>	<div><div>1</div></div>
ii) Irritable	<div><div>1</div></div>	<div><div>1</div></div>
iii) Depressed	<div><div>1</div></div>	<div><div>1</div></div>
iv) Anxious	<div><div>1</div></div>	<div><div>1</div></div>
v) Other (please tick & describe)	<div><div>1</div></div>	<div><div>1</div></div>

.....

A11. Please give below your present weights and measurements if you know them.

- a) weight  kg or  stones  pounds
- b) height  cm or  ft  in
- c) inside leg measurement  cm or  in
- d) bust  cm or  in
- e) hips  cm or  in
- f) waist  cm or  in

A12. a) How many cigarettes do you smoke nowadays per day? (If none, put 00)

- i) weekday ii) weekend day



b) Do you smoke:

**Yes  
every day**

**Yes  
sometimes**

**No  
never**

(i) pipe

  
1

  
2

  
3

(ii) cigar/cigarillo

  
1

  
2

  
3

## **SECTION B: LIFE IN THE LAST 4 WEEKS**

- B1. During the past 4 weeks what was the hardest physical activity you could do for at least 2 minutes?

Very heavy e.g. run at a fast pace	<div>1</div>
Heavy e.g. jog at a slow pace	<div>2</div>
Moderate e.g. walk at a fast pace	<div>3</div>
Light e.g. walk at a medium pace	<div>4</div>
Very light e.g. walk at a slow pace	<div>5</div>

- B2. During the past 4 weeks how much have you been bothered by emotional problems such as feeling anxious, depressed, or downhearted and sad?

Not at all	<div>1</div>
Hardly ever	<div>2</div>
Sometimes	<div>3</div>
Quite a lot	<div>4</div>
A great deal	<div>5</div>

- B3. During the past 4 weeks how much difficulty have you had doing your usual activities both inside and outside the house, because of your physical and/or emotional health?

No difficulty	<div>1</div>
A little difficulty	<div>2</div>
Some difficulty	<div>3</div>
Much difficulty	<div>4</div>
Could not do	<div>5</div>

B4. During the past 4 weeks how much has your physical and/or emotional health limited your social activities with family, friends, neighbours or groups?

Not at all	<div>1</div>
Hardly ever	<div>2</div>
Sometimes	<div>3</div>
Quite a lot	<div>4</div>
A great deal	<div>5</div>

B5. During the past 4 weeks how much bodily pain have you generally had?

None at all	<div>1</div>
Very mild pain	<div>2</div>
Mild pain	<div>3</div>
Moderate pain	<div>4</div>
Severe pain	<div>5</div>

B6. During the past 4 weeks how would you rate your health in general?

Excellent	<div>1</div>
Very good	<div>2</div>
Good	<div>3</div>
Fair	<div>4</div>
Poor	<div>5</div>

B7. During the past 4 weeks was someone available to help if you needed and wanted help?

Yes, as much as I wanted	<input type="text" value="1"/>
Yes, quite a bit	<input type="text" value="2"/>
Yes some of the time	<input type="text" value="3"/>
Yes, a little of the time	<input type="text" value="4"/>
No, not at all	<input type="text" value="5"/>

B8. How well have things been going for you during the past 4 weeks?

Very well	<input type="text" value="1"/>
Pretty good	<input type="text" value="2"/>
An equal mix of good and bad	<input type="text" value="3"/>
Pretty bad	<input type="text" value="4"/>
Very bad	<input type="text" value="5"/>
Dreadful	<input type="text" value="6"/>

## **SECTION C: YOUR HUSBAND/PARTNER**

C1. a) Do you currently have a husband or partner?

yes, a husband

yes, a male partner

yes, a female partner

no partner

→ If **no partner**, go to Section D on page 28

If **yes**,

b) does your partner or husband live with you?

Yes

No

→ If **no**, go to C2 below

If **yes**,

c) how long have you lived together?

years

months

d) is this the same partner or husband as the one you had when the study child had his/her 9<sup>th</sup> birthday?

Yes the same

No, a new partner

I don't remember

**The section below is concerned with your relationship with your partner. (The partner will be referred to as 'he', although the questions refer to all partners.)**

C2. How would you assess your husband/partner's physical health?

always fit and well

mostly well and healthy

often feels unwell

hardly ever feels well

- C3. Below are listed a number of conditions which your husband/partner might have had. Please indicate whether he has had any of these since your study child's 10<sup>th</sup> birthday.

In the last 2 years husband/partner had:	Yes, and saw a doctor	Yes, but did not see a doctor	No, not at all	Do not know
a) headaches or migraine	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
b) indigestion	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
c) epilepsy	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
d) depression	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
e) anxiety or nerves	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
f) haemorrhoids/piles	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
g) cough or cold	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
h) influenza	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
i) bronchitis	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
j) high blood pressure (hypertension)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
k) diabetes	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
l) schizophrenia	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
m) drink (alcohol) problem	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
n) stomach ulcer	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
o) asthma or wheezing	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
p) eczema	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
q) psoriasis	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
r) arthritis	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
s) urinary infection	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
t) rheumatism	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
u) back pain, sciatica or slipped disc	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>

In the last 2 years husband\partner had:		Yes, and saw a doctor	Yes, but did not see a doctor	No, not at all	Do not know
v)	syphilis	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
w)	gonorrhoea	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>
x)	other condition(s) (please tick and describe)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="9"/>

.....

C4. Below are some statements about fathers' and partners' relationships with young children. Please indicate how you feel in your particular situation.

In regard to the study child:		This is always how I feel	This is sometimes how I feel	I never feel this way
a)	He really loves this child	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
b)	He is glad that I had this child when I did	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
c)	I like to watch him play with the child	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
d)	I am afraid to leave the child alone with him because I think he might be violent	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
e)	He seems to feel very close to the child	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
f)	This child gets on his nerves	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
g)	He really cannot bear it when this child cries or whines	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
h)	I think he is interested as he watches the child develop	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>

		<b>This is always how I feel</b>	<b>This is sometimes how I feel</b>	<b>I never feel this way</b>
C4. (cont.)				
i)	He feels anxious when the child is staying with others	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
j)	He doesn't mind the mess that surrounds children	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
k)	This child makes him very happy	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>

		<b>(i) weekday</b>	<b>(ii) weekend day</b>
C5.	a) How many cigarettes does your husband or partner currently smoke <u>per day</u> ? (If none, put 00)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

	<b>Yes every day</b>	<b>Yes sometimes</b>	<b>No never</b>
b) Does he smoke:			
(i) pipe	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
(ii) cigar/cigarillo	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>

C6. a) Is your husband/partner currently employed?

Yes  No  → **If no, go to C7 on page 21**

**If yes,**

b) (i) What is his occupation?.....

(ii) Please give industry or trade .....

c) Has he had the same job since the study child's 10<sup>th</sup> birthday?

Yes  No

C6. d) Does he work nights?

yes, always

yes, sometimes

no, never

e) Does he leave home for several days as part of his work?

yes, often

yes, occasionally

no, never

f) Does he work shifts?

yes, often

yes, occasionally

no, never

g) How many hours a week does he normally work?

i) If his hours are regular, please state how many

(put 99 if don't know)

ii) If his hours vary, please put the minimum

and the maximum

h) Does he usually work:

the basic no. of hours per week

basic hours plus paid overtime

longer than basic hours (but  
not paid extra)

self-employed - as long as  
necessary

C6. i) Does he get home after work before the study child is in bed?

yes, usually  yes, sometimes  no, never

C7. How would you rate him on these characteristics?

	<b>Almost always</b>	<b>Sometimes</b>	<b>Hardly ever</b>
a) helpful, co-operative	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
b) quiet, reserved	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
c) unreliable	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
d) sociable, outgoing	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
e) dominating	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
f) understanding	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
g) quick-tempered, easily upset	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
h) cheerful, easygoing	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>

C8. Who does these various household tasks?

	<b>Me always</b> ↓	<b>Me mostly</b> ↓	<b>Sometimes me, some- times he does</b>	<b>He does mostly</b> ↓	<b>He does always</b> ↓	<b>Someone else</b> ↓
a) shopping for groceries	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>
b) cooking	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>
c) cleaning	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>
d) repairs in home	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>
e) looking after children	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>
f) washing clothes	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>
g) ironing	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>

C9. Who decides:

		<b>Me always</b> ↓	<b>Me mostly</b> ↓	<b>Sometimes me, some- times he does</b>	<b>He does mostly</b> ↓	<b>He does always</b> ↓
a)	how to spend free time	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
b)	how much to see family or friends	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
c)	when to do repairs or redecorate	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
d)	how we should spend our money	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

C10. People vary greatly in the amount they are satisfied or dissatisfied with their relationship. How do you feel about the following aspects of your life together?

		<b>Very satisfied</b>	<b>Moderately satisfied</b>	<b>Somewhat dissatisfied</b>	<b>Very dissatisfied</b>
a)	handling family finances	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
b)	demonstrations of affection	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
c)	sex	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
d)	amount of time spent together	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
e)	making major decisions	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
f)	household tasks	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
g)	leisure time interests & activities	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>

C11. a) How often recently have you been irritable with your husband or partner?

not at all	<div>1</div>	less than once a week	<div>2</div>	1-2 times a week	<div>3</div>	3-6 times a week	<div>4</div>	every day	<div>5</div>
------------	--------------	-----------------------	--------------	------------------	--------------	------------------	--------------	-----------	--------------

C11. b) How often has he been irritable with you?

not		less than		1-2 times		3-6 times		every	
at all	<input type="text" value="1"/>	once a week	<input type="text" value="2"/>	a week	<input type="text" value="3"/>	a week	<input type="text" value="4"/>	day	<input type="text" value="5"/>

C12. a) How many arguments or disagreements have you had with one another in the past three months?

None	<input type="text" value="1"/>	1-3	<input type="text" value="2"/>	4-7	<input type="text" value="3"/>	8-13	<input type="text" value="4"/>	14 or more	<input type="text" value="5"/>
------	--------------------------------	-----	--------------------------------	-----	--------------------------------	------	--------------------------------	------------	--------------------------------

In the past 3 months, have any of these happened?

		<b>Yes, I did this</b>	<b>Yes, he did this</b>	<b>Yes, we both did this</b>	<b>No, not at all</b>
b)	not speaking for more than half an hour	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
c)	one of you walking out of the house	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
d)	shouting or calling one another names	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
e)	hitting or slapping	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
f)	throwing or breaking things	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

C13. In the past three months how often have you done these things **with your husband/partner**?

		Never ↓	Less than once a month	Less than once a week	At least once a week
<b>Together we have:</b>					
a)	gone out for a meal	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
b)	gone out for a drink	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
c)	visited friends	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
d)	visited family	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
e)	gone to the cinema or theatre	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
f)	other (please tick & describe)		<div>2</div>	<div>3</div>	<div>4</div>

.....

C14. a) How many evenings a month do you go out and do things **on your own** or with your own friends?

none	<div>1</div>	once	<div>2</div>	2-3 times	<div>3</div>
4-7 times	<div>4</div>	8 or more times	<div>5</div>		

b) How many times a month does your husband/partner go out and do things **on his own** or with friends?

none	<div>1</div>	once	<div>2</div>	2-3 times	<div>3</div>
4-7 times	<div>4</div>	8 or more times	<div>5</div>		

C15. How often in a week, on average, would you and your husband/partner:

	Never ↓	Less than once a week	1-3 times a week	Most days ↓
a) discuss work or how the day has gone	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
b) laugh together	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
c) calmly talk over something (e.g. the news, a hobby or interest)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
d) kiss or hug	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
e) make plans	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
f) talk over feelings or worries	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

C16. a) Which of the following statements about alcohol best applies to your husband/partner:

Never drinks alcohol	<input type="text" value="1"/>
Very occasionally (less than once a week)	<input type="text" value="2"/>
Occasionally (at least once a week )	<input type="text" value="3"/>
Drinks 1-2 glasses* nearly every day	<input type="text" value="4"/>
Drinks 3-9 glasses* every day	<input type="text" value="5"/>
Drinks at least 10 glasses a day	<input type="text" value="6"/>
Don't know	<input type="text" value="9"/>

[\*by glass we mean pub measures (1oz) of spirits, 1 glass of wine or ½ pint (¼ litre) of beer or cider]

C16. b) How many days **in the past month** do you think he had the equivalent of at least 2 pints of beer, 4 glasses of wine or 4 pub measures of spirit?

every day	<input type="text" value="1"/>	more than 10 days	<input type="text" value="2"/>
5-10 days	<input type="text" value="3"/>	3-4 days	<input type="text" value="4"/>
1-2 days	<input type="text" value="5"/>	none	<input type="text" value="6"/>

C17. Below are attitudes and behaviours which people reveal in their close relationships. Please rate your husband/partner's attitudes and behaviour towards you in recent times and tick the most appropriate box for each item.

My husband/partner:		Very true	Moderately true	Somewhat true	Not at all true
a)	Is very considerate of me	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
b)	Wants me to take his side in an argument	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
c)	Wants to know exactly what I'm doing and where I am	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
d)	Is a good companion	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
e)	Is affectionate to me	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
f)	Is clearly hurt if I don't accept his views	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
g)	Tends to try to change me	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
h)	Confides closely in me	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
i)	Tends to criticise me over small issues	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
j)	Understands my problems and worries	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
k)	Tends to order me about	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
l)	Insists I do exactly as I'm told	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
m)	Is physically gentle and considerate	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

C17. cont.

	<b>Very true</b>	<b>Moderately true</b>	<b>Somewhat true</b>	<b>Not at all true</b>
<b>My husband/partner:</b>				
n) Makes me feel needed	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
o) Wants me to change in small ways	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
p) Is very loving to me	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
q) Seeks to dominate me	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
r) Is fun to be with	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
s) Wants to change me in big ways	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
t) Tends to control everything I do	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
u) Shows his appreciation of me	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
v) Is critical of me in private	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
w) Is gentle and kind to me	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
x) Speaks to me in a warm and friendly voice	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

## **SECTION D: PILLS AND POTIONS**

D1. Please indicate below if you have used any **medicines** (pills, syrups, inhalers, drops, sprays, suppositories, pessaries, ointments etc including homeopathic and herbal remedies) in the last 12 months.

Please include medicines prescribed by your doctor and also those you may have purchased over the counter. **(Do not include vitamins and supplements** unless taken for a specific medical condition, as these are covered in the next section).

If possible give the full name of the medicine and indicate how often it was used. If you need more lines for a particular category please include the additional medicines under the 'Other conditions' section at the end of this question on pages 31/32.

Medicine, pills, drops, ointment etc for:	Yes in past 12 months	If yes, give name of substance	How often did you take/use this?			
			Every day	Most days	Some times	Once or twice
a) Headache or or migraine	<input type="text"/>	i) ..... →	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		ii) ..... →	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) Backache	<input type="text"/>	i) ..... →	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		ii) ..... →	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) Period pain	<input type="text"/>	i) ..... →	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		ii) ..... →	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d) Other pain	<input type="text"/>	i) ..... →	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		ii) ..... →	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
e) Indigestion	<input type="text"/>	i) ..... →	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		ii) ..... →	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
f) Nausea	<input type="text"/>	i) ..... →	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		ii) ..... →	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

D1.		How often did you take/use this?				
Medicine, pills, drops, ointment etc for:	Yes in past 12 months	If yes, give name of substance	Every day	Most days	Some times	Once or twice
g) Vomiting	<input type="text" value="1"/>	i) .....	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
h) Diarrhoea	<input type="text" value="1"/>	i) .....	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
i) Piles or haemorrhoids	<input type="text" value="1"/>	i) .....	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
j) Constipation	<input type="text" value="1"/>	i) .....	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
k) Depression	<input type="text" value="1"/>	i) .....	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
l) Anxiety or nerves	<input type="text" value="1"/>	i) .....	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
m) Sleeping	<input type="text" value="1"/>	i) .....	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
n) Psoriasis	<input type="text" value="1"/>	i) .....	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
o) Eczema	<input type="text" value="1"/>	i) .....	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

D1.		How often did you take/use this?				
Medicine, pills, drops, ointment etc for:	Yes in past 12 months	If yes, give name of substance	Every day	Most days	Some times	Once or twice
p) Asthma	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
q) Hay fever	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
r) Other allergies	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
s) Sore throat	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
t) Cough	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
u) A cold	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
v) Flu	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
w) Other infection	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

D1.		How often did you take/use this?				
Medicine, pills, drops, ointment etc for:	Yes in past 12 months	If yes, give name of substance	Every day	Most days	Some times	Once or twice
x) Thrush	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
y) Cystitis	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
z) Diabetes	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
za) Epilepsy	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
zb) High blood pressure	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
zc) Oral contraceptive	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
zd) HRT (hormone replacement therapy)	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ze) Other condition (please tick & describe)	<input type="checkbox"/>	.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1					
zf) Other condition (please tick & describe)	<input type="checkbox"/>	.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1					

D1. **How often did you take/use this?**

Medicine, pills, drops, or ointment etc for:	Yes in past 12 months	If yes, give name of substance	Every day	Most days	Some times	Once or twice
zg) Other condition (please tick & describe)	<input type="checkbox"/>	.....→	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
zh) Other condition (please tick & describe)	<input type="checkbox"/>	.....→	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
zi) Took/used no medicines, pills, drops or ointment	<input type="checkbox"/>					

D2. Vitamin, mineral and other supplements are widely used. Some people take them regularly for their health, whereas others may use them more sporadically to try to improve a specific area of their health. Please indicate below whether you have used such supplements regularly, occasionally or not at all **in the last 12 months**.

		Used in last 12 months		
		Regularly	Occasionally	Not at all
a)	Vitamins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b)	Minerals (e.g. calcium, iron)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c)	Oil supplements e.g. fish oils, evening primrose oil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d)	Other supplements e.g. Ginseng	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D3. Please describe below any vitamins, minerals such as iron or calcium or other supplements taken in the **past month** and indicate how often you used them.

	Every day	Most days	About 1-2 times a week	Less than once a week	Not at all
a) <b>Vitamins</b> (Please say which vitamins and give brand name)					
i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Every day	Most days	About 1-2 times a week	Less than once a week	Not at all
--	--------------	--------------	------------------------------	--------------------------------	---------------

**b) Mineral supplements**

(Please say which minerals e.g. iron, calcium, and give brand name)

i) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
ii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
iii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

**c) Oil supplements**

(Please say which, e.g. fish oils, Evening Primrose oil, and give brand name)

i) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
ii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
iii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

**d) Other supplements**

(Please say which, e.g. Ginseng, Royal Jelly, and give brand name)

i) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
ii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
iii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

## **SECTION E: BREAKING THE LAW**

Most of us have broken the law at some time or other, maybe when larking around in our youth, or on the spur of the moment, or because of circumstances in our lives.

In this section there are some questions about such experiences which we hope you will share with us.

**As always, your answers are completely confidential and cannot be linked to your name.**

If you are not happy to complete this section for any reason at all, please **go to Section F on page 43**

E1. a) Have you **ever** been in trouble with the law?

Yes  No  → **If no, go to E2 below**

b) When did this happen? (Please tick all that apply)

(i) As a child (before the age of 13)   
(ii) As a teenager   
(iii) As an adult

c) Has this happened in the last year? Yes  No

E2. a) Apart from speeding have you **ever** been convicted of an offence?

Yes  No  → **If no, go to E3 on page 35**

b) When did this happen? (Please tick all that apply)

(i) As a child (before the age of 13)   
(ii) As a teenager   
(iii) As an adult

c) Has this happened in the last year? Yes  No

This next set of questions are about things relating to **vehicles**. By vehicles we mean cars, vans, motorbikes, or other motor vehicles.

- E3. a) Have you **ever** driven a vehicle on a public road without vehicle insurance or a driving licence?

Yes ☐\_1\_ No ☐\_2\_ → If **no**, go to E4 below

- b) When did this happen? (Please tick all that apply)

(i) As a child (before the age of 13) ☐\_1\_  
(ii) As a teenager ☐\_1\_  
(iii) As an adult ☐\_1\_

- c) Has this happened in the last year? Yes ☐\_1\_ No ☐\_2\_

- E4. a) Have you **ever** driven a vehicle when you thought at the time you could have been over the legal limit for alcohol?

Yes ☐\_1\_ No ☐\_2\_ → If **no**, go to E5 below

- b) When did this happen? (Please tick all that apply)

(i) As a teenager ☐\_1\_  
(ii) As an adult ☐\_1\_

- c) Have you done this in the last year? Yes ☐\_1\_ No ☐\_2\_

- E5. a) Have you **ever** stolen, or driven a vehicle away without permission, even if the owner got it back?

Yes ☐\_1\_ No ☐\_2\_ → If **no**, go to E6 on page 36

- E5. b) When did this happen? (Please tick all that apply)
- (i) As a child (before the age of 13) ☐<sub>1</sub>
- (ii) As a teenager ☐<sub>1</sub>
- (iii) As an adult ☐<sub>1</sub>
- c) Have you done this in the last year? Yes ☐<sub>1</sub> No ☐<sub>2</sub>
- E6. a) Have you **ever** stolen any parts off a vehicle or anything from inside a vehicle?
- Yes ☐<sub>1</sub> No ☐<sub>2</sub> → If **no**, go to E7 below
- b) When did this happen? (Please tick all that apply)
- (i) As a child (before the age of 13) ☐<sub>1</sub>
- (ii) As a teenager ☐<sub>1</sub>
- (iii) As an adult ☐<sub>1</sub>
- c) Have you done this in the last year? Yes ☐<sub>1</sub> No ☐<sub>2</sub>
- E7. a) Have you **ever** damaged any vehicle in any way on purpose, for example by scratching it or breaking a window?
- Yes ☐<sub>1</sub> No ☐<sub>2</sub> → If **no**, go to E8 on page 37
- b) When did this happen? (Please tick all that apply)
- (i) As a child (before the age of 13) ☐<sub>1</sub>
- (ii) As a teenager ☐<sub>1</sub>
- (iii) As an adult ☐<sub>1</sub>
- c) Have you done this in the last year? Yes ☐<sub>1</sub> No ☐<sub>2</sub>

**These next questions are about other things you may have done.**

- E8. a) Have you **ever** gone into someone's home without their permission because you wanted to steal or damage something?

Yes ☐<sub>1</sub> No ☐<sub>2</sub> → **If no, go to E9 below**

- b) When did this happen? (Please tick all that apply)

(i) As a child (before the age of 13) ☐<sub>1</sub>  
(ii) As a teenager ☐<sub>1</sub>  
(iii) As an adult ☐<sub>1</sub>

- c) Have you done this in the last year? Yes ☐<sub>1</sub> No ☐<sub>2</sub>

- E9. a) Thinking about other types of buildings such as a factory, office, shop, hospital, school etc. Have you **ever** gone into any of these types of buildings, without permission because you wanted to steal or damage something?

Yes ☐<sub>1</sub> No ☐<sub>2</sub> → **If no, go to E10 below**

- b) When did this happen? (Please tick all that apply)

(i) As a child (before the age of 13) ☐<sub>1</sub>  
(ii) As a teenager ☐<sub>1</sub>  
(iii) As an adult ☐<sub>1</sub>

- c) Have you done this in the last year? Yes ☐<sub>1</sub> No ☐<sub>2</sub>

- E10. a) Have you **ever** painted or written graffiti on anything without permission?

Yes ☐<sub>1</sub> No ☐<sub>2</sub> → **If no, go to E11 on page 38**

E10. b) When did this happen? (Please tick all that apply)

- (i) As a child (before the age of 13) ☐  
1
- (ii) As a teenager ☐  
1
- (iii) As an adult ☐  
1

c) Have you done this in the last year? Yes ☐  
1 No ☐  
2

E11. a) Have you **ever** damaged anything that didn't belong to you or your family on purpose, for example by burning, smashing, or breaking it?

Yes ☐  
1 No ☐  
2 → If **no**, go to E12 below

b) When did this happen? (Please tick all that apply)

- (i) As a child (before the age of 13) ☐  
1
- (ii) As a teenager ☐  
1
- (iii) As an adult ☐  
1

c) Have you done this in the last year? Yes ☐  
1 No ☐  
2

If **yes**,

d) In the past year, what have you damaged that didn't belong to you?

.....

E12. a) Have you **ever** used force, violence or threats against anyone in order to steal from a shop, petrol station, bank or other business?

Yes ☐  
1 No ☐  
2 → If **no**, go to E13 on page 39

b) When did this happen? (Please tick all that apply)

- (i) As a child (before the age of 13) ☐  
1
- (ii) As a teenager ☐  
1
- (iii) As an adult ☐  
1

E12. c) Have you done this in the last year? Yes ☐1 ☐2 No

E13. a) Have you **ever** used force, violence or threats, against anyone in order to steal something from them?

Yes ☐1 No ☐2 → If **no**, go to E14 below

b) When did this happen? (Please tick all that apply)

(i) As a child (before the age of 13) ☐1

(ii) As a teenager ☐1

(iii) As an adult ☐1

c) Have you done this in the last year? Yes ☐1 ☐2 No

E14. a) Have you without using force, violence or threats, **ever** stolen anything someone was carrying or wearing, for example by taking something from their hand, pocket or bag?

Yes ☐1 No ☐2 → If **no**, go to E15 below

b) When did this happen? (Please tick all that apply)

(i) As a child (before the age of 13) ☐1

(ii) As a teenager ☐1

(iii) As an adult ☐1

c) Have you done this in the last year? Yes ☐1 ☐2 No

E15. a) Have you without using force, violence or threats, **ever** stolen anything from a shop?

Yes ☐1 No ☐2 → If **no**, go to E16 on page 40

E15. b) When did this happen? (Please tick all that apply)

- (i) As a child (before the age of 13) ☐  
1
- (ii) As a teenager ☐  
1
- (iii) As an adult ☐  
1

c) Have you done this in the last year? Yes ☐  
1 No ☐  
2

E16. a) Have you **ever** stolen anything from where you work(ed) or went to school?

Yes ☐  
1 No ☐  
2 → If **no**, go to E17 below

b) When did this happen? (Please tick all that apply)

- (i) As a child (before the age of 13) ☐  
1
- (ii) As a teenager ☐  
1
- (iii) As an adult ☐  
1

c) Have you done this in the last year? Yes ☐  
1 No ☐  
2

d) In the past year, what have you stolen from work?

.....

E17. a) Apart from anything you have already mentioned, have you **ever** stolen anything else?

Yes ☐  
1 No ☐  
2 → If **no**, go to E18 on page 41

b) When did this happen? (Please tick all that apply)

- (i) As a child (before the age of 13) ☐  
1
- (ii) As a teenager ☐  
1
- (iii) As an adult ☐  
1

- E17. c) Have you done this in the last year? Yes ☐1 ☐2 No
- d) In the past year, what have you stolen ?  
 .....

- E18. a) Have you **ever** used force on anyone on purpose, for example scratching, hitting, kicking, throwing things, which you think physically injured them in some way?

Yes ☐1 No ☐2 → If **no**, go to E19 below

- b) When did this happen? (Please tick all that apply)

- (i) As a child (before the age of 13) ☐1
- (ii) As a teenager ☐1
- (iii) As an adult ☐1

- c) Have you done this in the last year? Yes ☐1 ☐2 No

- E19. a) Have you **ever** carried a weapon in case you needed it in a fight?

Yes ☐1 No ☐2 → If **no**, go to E20 below

- b) When did this happen? (Please tick all that apply)

- (i) As a child (before the age of 13) ☐1
- (ii) As a teenager ☐1
- (iii) As an adult ☐1

- c) Have you done this in the last year? Yes ☐1 ☐2 No

- E20. a) Have you **ever** used a weapon to injure anyone on purpose?

Yes ☐1 No ☐2 → If **no**, go to E21 on page 42

E20. b) When did this happen? (Please tick all that apply)

- (i) As a child (before the age of 13) ☐  
1
- (ii) As a teenager ☐  
1
- (iii) As an adult ☐  
1

c) Have you done this in the last year? Yes ☐  
1 No ☐  
2

E21. If you answered yes to any of the questions in Section E, have you regretted any of your actions?

No, not at all ☐  
1 Yes, a little ☐  
2 Yes, quite a lot ☐  
3 Yes, very much ☐  
4

## **SECTION F: YOUR FAMILY AND FRIENDS**

F1. How many of your relatives and your husband/partner's relatives do you see at least twice a year?

None	1	2-4	more than 4
<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>

F2. About how many friends do you have?

None	1	2-4	more than 4
<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>

F3. Overall, would you say you belong to a close circle of friends?

Yes	<div>1</div>	No	<div>2</div>
-----	--------------	----	--------------

F4. How many people are there that you can talk to about personal problems?

None	1	2-4	more than 4
<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>

F5. How many people talk to you about their personal problems or their private feelings?

None	1	2-4	more than 4
<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>

F6. If you have to make an important decision, how many people are there with whom you can discuss it?

None	1	2-4	more than 4
<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>

F7. How many people are there among your family and friends from whom you could borrow £200 if you needed to?

None	1	2-4	more than 4
<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>

F8. How many of your family and friends would help you in times of trouble?

None	1	2-4	more than 4
<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

F9. During the last month, how many times did you get together with one or more friends?

None	1	2-4	more than 4
<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

F10. During the last month, how many times did you get together with one or more of your relatives or your husband/partner's relatives?

None	1	2-4	more than 4
<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

The following statements are about the help and support you have.

		<b>This is exactly how I feel</b>	<b>This is often how I feel</b>	<b>This is how I sometimes feel</b>	<b>I never feel this way</b>	
F11	I have no one to share my feelings with	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	
F12	My husband/partner provides the emotional support I need	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<b>no husband/ partner</b> <input type="text" value="7"/>
F13	There are other mothers with whom I can share my experiences	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	
F14	I believe in moments of difficulty my neighbours would help me	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	

		<b>This is exactly how I feel</b>	<b>This is often how I feel</b>	<b>This is how I sometimes feel</b>	<b>I never feel this way</b>	<b>no husband/ partner</b>
F15	I'm worried that my husband/partner might leave me	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	7 <input type="text"/>
F16	There is always someone with whom I can share my happiness and excitement about my child	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	
F17	If I feel tired I can rely on my husband/partner to take over	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	7 <input type="text"/>
F18	If I was in financial difficulty I know my family would help if they could	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	
F19	If I was in financial difficulty I know my friends would help if they could	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	
F20	If all else fails I know the state will support and assist me	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	

## **SECTION G: YOUR DIET**

G1. How many times nowadays do you eat the following foods? Please answer every question even if you never eat the food (in this case tick “never or rarely”).

		<b>Never or rarely</b>	<b>Once in 2 weeks</b>	<b>1-3 times a week</b>	<b>4-7 times a week</b>	<b>More than 7 times a week</b>
a)	Meat sausages and burgers	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
b)	Vegetarian sausages, vegeb主rgers	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
c)	Meat pies/pasties (pork pie, steak/meat pie etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
d)	Vegetarian pies/pasties (cheese and onion pasty, vegetable samosa, onion bhaji, vegetable grills etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
e)	Ham, bacon, paté and cold meats (e.g. salami, luncheon meat, garlic sausage etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
f)	Meat roast, chops, stews and curries, shepherds pie, bolognaise etc. (beef, lamb pork mince)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
g)	Liver, kidney, heart	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
h)	Chicken/turkey in crispy coating (chicken nuggets, turkey burgers, chicken fingers etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

G1.		Never or rarely	Once in 2 weeks	1-3 times a week	4-7 times a week	More than 7 times a week
i)	Poultry: roast, grilled, fried boiled, stewed (chicken, turkey etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
j)	Shellfish (prawns, crab, cockles, mussels etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
k)	White fish in breadcrumbs or batter (fish fingers/shapes, chip shop fish, breaded cod, plaice or haddock etc.).	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
l)	White fish without coating (grilled fish, cod in parsley sauce etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
m)	Tuna	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
n)	Other fish (pilchards, sardines, mackerel, herrings, kippers, trout, salmon etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
o)	Eggs, quiche/flans, omelettes etc.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
p)	Cheese	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
q)	Pizza	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
r)	Oven chips or roast potatoes (cooked in fat or oil)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
s)	Fried chips, potato waffles and croquettes, Alphabites etc.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
t)	Boiled, mashed, jacket potatoes	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

G1.		Never or rarely	Once in 2 weeks	1-3 times a week	4-7 times a week	More than 7 times a week
u)	Rice (boiled, or fried, <u>not</u> rice pudding)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
v)	Canned pasta (spaghetti rings, ravioli, macaroni cheese etc.) Pot Noodles, Super Noodles etc.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
w)	Boiled pasta (e.g. spaghetti fusilli, lasagne), bulgar wheat or cous-cous	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

G2. How often do you have fried food, excluding chips? e.g. Fried bacon and eggs, fried fish, chops, steak, or beefburgers etc.

Never or rarely	<div>1</div>
Once in 2 weeks	<div>2</div>
1-3 times a week	<div>3</div>
4-7 times a week	<div>4</div>
More than 7 times a week	<div>5</div>

G3. Do you eat the fat on meat?

yes, all of it	<div>1</div>
yes, some of it	<div>2</div>
no, always leave the fat	<div>3</div>
never eat meat	<div>4</div>

G4. How many times nowadays do you eat;

		<b>Never or rarely</b>	<b>Once in 2 weeks</b>	<b>1-3 times a week</b>	<b>4-7 times a week</b>	<b>More than 7 times a week</b>
a)	Baked beans	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
b)	Peas, broad beans	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
c)	Sweetcorn	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
d)	Carrots	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
e)	Other root vegetables (turnip, swede, parsnip etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
f)	Tomatoes (cooked or raw)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
g)	Salads (lettuce, cucumber, peppers, other raw vegetables)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
h)	Pulses – and pulse dishes (dahl, lentil soup, falafel, dried peas, beans, chick peas etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
i)	Soya ‘Meat’, TVP, Bean curd, (Tofu, Miso etc.), Quorn	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
j)	Peanuts, peanut butter	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
k)	Other nuts (e.g. cashews), nut roast etc.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
l)	Canned fruit	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
m)	Yoghurt, Fromage Frais	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

		Never or rarely	Once in 2 weeks	1-3 times a week	4-7 times a week	More than 7 times a week
G4.						
n)	Milk puddings (e.g. rice pudding, semolina), mousse Angel Delight etc.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
o)	Ice cream, choc ice, chocolate ice cream bar etc.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
p)	Pudding (e.g. fruit pie, crumble, cheesecake, gateaux)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
q)	Custard, cream, Elmlea, Tip-Top, evaporated milk etc. on puddings	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
r)	Cakes or buns (fruit cake, sponge, teacake, doughnut, flapjack, scone, custard tart, cream cake etc.)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
s)	Crispbreads (Ryvita, crackerbread etc.)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
t)	Ketchup/brown sauce etc.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
u)	Mayonnaise, salad cream or dressing etc.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

G5. In total, how many portions of green vegetables e.g. broccoli, cauliflower, courgettes, cabbage, leeks, green beans do you eat in a week?

<input type="text"/>	<input type="text"/>	portions
----------------------	----------------------	----------

a) Out of these total portions, how many are dark green leafy vegetables e.g. broccoli, Brussel sprouts, cabbage, spinach etc.?

<input type="text"/>	<input type="text"/>	portions
----------------------	----------------------	----------

G6. In total how many pieces of raw fruit e.g. apple, banana, orange, Satsuma, peach, grapes, strawberries etc. do you eat in a week? (For small fruit such as grapes etc, one “piece” will be a “helping” e.g. a small dish of strawberries or a small sprig of grapes.)

<input type="text"/>	<input type="text"/>
----------------------	----------------------

- G6. a) Out of these, how many of them are citrus fruit e.g. tangerine, orange, Satsuma, grapefruit etc.?

--	--

- G7. a) Do you eat breakfast cereals at all?

Yes 

1
---

No 

2
---

→ If **no**, go to G9 on page 52

If **yes**, What type of breakfast cereal do you eat nowadays?

		Never or rarely	Once in 2 weeks	1-3 times a week	4-7 times a week	More than 7 times a week
b)	Oat cereals (e.g. porridge Ready Brek, muesli)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
c)	Wholegrain or bran cereals (e.g. All Bran, Bran Flakes, Weetabix, Wheatflakes, Fruit & Fibre, Shredded Wheat)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
d)	Sugar/honey coated cereals (e.g. Frosties, Honeynut Loops, Crunchynut cornflakes)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
e)	Other cereals (e.g. Cornflakes Rice Krispies, Special K)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

- G8. a) How many teaspoons of sugar do you have on cereal?

None	$\frac{1}{2}$ Teaspoon	One teaspoon	2 teaspoons	More than 2 teaspoons					
<table border="1"><tr><td>1</td></tr></table>	1	<table border="1"><tr><td>2</td></tr></table>	2	<table border="1"><tr><td>3</td></tr></table>	3	<table border="1"><tr><td>4</td></tr></table>	4	<table border="1"><tr><td>5</td></tr></table>	5
1									
2									
3									
4									
5									

- b) How many times **per week** do you have milk on cereal? 

--	--

 times

G9. How often nowadays do you eat:

	<b>Never or rarely</b>	<b>Once in 2 weeks</b>	<b>1-3 times a week</b>	<b>4-7 times a week</b>	<b>More than 7 times a week</b>
a) Crisps, corn snacks (e.g. Wotsits, Quavers, tortilla chips etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
b) Full-coated chocolate biscuits (e.g. Club, Kit Kat, Penguin, Breakaway etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
c) Other biscuits (e.g. Rich tea, shortcakes, digestive and chocolate digestive, Hob Nobs)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
d) Chocolate (dairy milk or plain nut, fruit, filled etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
e) Sweets (individual, packets or bars, peppermints, boiled sweets, toffees etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

G10. On days when you eat biscuits, how many biscuits do you normally eat in that day?

 biscuits

G11. On days when you eat sweets, how many individual sweets do you normally eat in that day?

<b>1-2 sweets</b>	<b>3-5 sweets</b>	<b>6-10 sweets</b>	<b>11-20 sweets</b>	<b>more than 20 sweets</b>	<b>I never have sweets</b>
<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>	<div>7</div>

G12. On days when you have chocolate or chocolate bars (e.g. Mars bars, Dairy Milk):

a) What size bar do you have?

**Usually eat individual  
chocolates/squares**

1

**Usually eat whole bars**

2

**Never have chocolate**

3

→ **Go to G13  
on page 53**

G12. b) How many chocolates/bars of **this** size do you usually eat in **that** day?

**½ or less**

**1**

**2**

**3 or more**





G13. How many times a week nowadays do you drink:

		<b>Never or rarely</b>	<b>Once in 2 weeks</b>	<b>1-3 times a week</b>	<b>4-7 times a week</b>	<b>More than 7 times a week</b>
a)	Pure fruit juice from a carton or freshly squeezed including tomato juice	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b)	Squash, fruit drinks	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c)	Cola drinks (e.g. Coca Cola, Pepsi etc.)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d)	Other fizzy drinks (e.g. lemonade, fizzy water)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
e)	Bottled still water	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
f)	Water from tap	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
g)	Milk on its own	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
h)	Flavoured milk drinks (e.g. Horlicks, cocoa, drinking chocolate, Ovaltine, milkshakes) or yoghurt drinks	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

G14. When you have soft drinks (e.g. lemonade, cola, squash) how often are they low calorie, diet or reduced sugar drinks?

usually

sometimes

not at all

I don't drink soft drinks

G15. When you have cola drinks how often are they decaffeinated?

usually	<input type="text" value="1"/>
sometimes	<input type="text" value="2"/>
not at all	<input type="text" value="3"/>
I don't drink cola	<input type="text" value="4"/>

G16. What type of bread do you eat **most often**? (Tick all that apply)

	Yes, usually	Yes, sometimes	No, not at all
a) White bread	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
b) Soft grain white bread	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
c) Brown/granary bread	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
d) Wholemeal bread	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
e) Chappatis, pitta bread	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
f) Naan bread	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
g) Other (please tick and describe)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>

.....

G17. a) How many slices of bread, rolls or chappatis do you eat on a usual day? (**include bought sandwiches**)

less than 1	<input type="text" value="1"/>	1-2	<input type="text" value="2"/>	3-4	<input type="text" value="3"/>	5 or more	<input type="text" value="4"/>
-------------	--------------------------------	-----	--------------------------------	-----	--------------------------------	-----------	--------------------------------

b) How many slices of bread (or rolls) spread with butter or margarine do you eat each day on average? (include shop bought sandwiches)

<input type="text"/>	<input type="text"/>	slices
----------------------	----------------------	--------

- G17. c) How many slices of bread (or rolls) spread with sweet things such as jam/honey/chocolate spread etc. do you eat each day on average?

--	--

slices

- G18. What sort of fat do you mainly use?

		(i) On bread or vegetables		(ii) For frying	
		Yes	No	Yes	No
a)	Butter, ghee, dripping, lard, solid cooking fat	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
b)	Full-fat polyunsaturated margarine (e.g. Flora, Vitalite, sunflower margarine)	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
c)	Other full-fat margarine (e.g. Blue Band, Stork, Clover, Golden Crown, Willow, supermarket own brand)	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
d)	Low-fat polyunsaturated margarine (e.g. Flora Lite, Vitalite Lite, low-fat Sunflower margarine)	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
e)	Other low-fat spread not polyunsaturated (e.g. Delight, St Ivel Gold)	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
f)	Sunflower oil, corn oil, soya oil	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
g)	Olive oil, hazelnut oil, rapeseed oil	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
h)	Other vegetable oil	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
i)	Other (please tick & describe)	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>

.....

.....

G19. What types of milk do you drink **most often**?

- |                                     |                                    |
|-------------------------------------|------------------------------------|
| a) Full fat (silver or gold top)    | <div><div>1</div><div></div></div> |
| b) Semi-skimmed (red stripe)        | <div><div>1</div><div></div></div> |
| c) Skimmed (blue stripe)            | <div><div>1</div><div></div></div> |
| d) Goat/sheep milk                  | <div><div>1</div><div></div></div> |
| e) Soya milk                        | <div><div>1</div><div></div></div> |
| f) Other (please tick and describe) | <div><div>1</div><div></div></div> |

.....

G20. a) Do you drink tea?

Yes 

1

No 

2

 → If **no**, go to G21 below

If **yes**,

- |  |                                    |   |
|--|------------------------------------|---|
| b) How many cups of tea do you drink in a day?<br>(do not include herbal teas) | <div><div></div><div></div></div>  | cups a day  |
| c) How many spoons of sugar in each cup?                                       | <div><div></div><div></div></div>  | spoons  |
| d) How many of the cups of tea that you drink<br>per day are decaffeinated?    | <div><div></div><div></div></div>  | cups a day  |
| e) Do you take milk in tea?  |                                    |   |
| Yes usually  | <div><div>1</div><div></div></div> | yes, sometimes <div><div>2</div><div></div></div> |
|  |                                    | No <div><div>3</div><div></div></div>             |

G21. a) Do you drink coffee?

Yes 

1

No 

2

 → If **no**, go to G22 on page 57

If **yes**,

- |  |                                   |            |
|--|-----------------------------------|------------|
| b) How many cups of coffee (real, instant or<br>decaffeinated) do you drink? | <div><div></div><div></div></div> | cups a day |
|--|-----------------------------------|------------|

- G21. c) How many spoons of sugar in each cup?   spoons
- d) How many of the cups of coffee you drink are decaffeinated?   cups a day
- e) How many of the cups of coffee you drink are made using real coffee (i.e not instant)?   cups a day
- f) How many of these are decaffeinated?   cups a day
- g) Do you take milk in coffee?
- Yes usually <sub>1</sub> Yes, sometimes <sub>2</sub> No <sub>3</sub>

- G22. a) During the last week **how many** of each type of alcoholic drink did you have on each day? (Please put a number).

		Mon.	Tues.	Wed.	Thurs	Fri.	Sat.	Sun.
(i)	Beer, lager or cider (no. of ½ pints)							
(ii)	Wine (no. of glasses)							
(iii)	Spirits (no. of single pub measures)							
(iv)	Martini, sherry, port or other 'fortified' wine (no. of single pub measures)							
(v)	Ready-mixed drinks (alcopops) e.g. Breezers, Smirnoff Ice, Reef etc (no. of bottles)							
(vi)	Other alcoholic drinks (please describe and write no. of glasses or measures)							
(vii)	Low alcohol drink (no. of glasses or ½ pints)							

- b) Is this week fairly typical of your alcohol drinking?

No <sub>1</sub> Yes <sub>2</sub> — **If yes, go to G23 on page 58**

- c) **If no**, would you normally drink:

More <sub>1</sub> Less <sub>2</sub>

G23. For your main meal of the day how often do you eat take-away foods or have meals out?

Never or rarely	<div>1</div>
1-3 times a month	<div>2</div>
1-2 times a week	<div>3</div>
3-4 times a week	<div>4</div>
5-7 times a week	<div>5</div>

G24. For your main meal of the day how often do you eat an oven/microwave ready or convenience meal (e.g. lasagne, ready prepared chilli con carne etc.)?

Never or rarely	<div>1</div>
1-3 times a month	<div>2</div>
1-2 times a week	<div>3</div>
3-4 times a week	<div>4</div>
5-7 times a week	<div>5</div>

G25. Are you at present a vegetarian?

Yes	<div>1</div>	No	<div>2</div>
-----	--------------	----	--------------

G26. Are you, at present a vegan (i.e. do not eat meat, poultry, fish, eggs, butter, milk or cheese)?

Yes	<div>1</div>	No	<div>2</div>
-----	--------------	----	--------------

G27. Are you at present on any other kind of special diet?

Yes	<div>1</div>	No	<div>2</div>
-----	--------------	----	--------------



If yes, please describe:

.....

.....

## **SECTION H: YOUR ENVIRONMENT**

H1. a) Do you have a mobile phone (i.e. one that can be used away from home)?

Yes  No  → Go to H2 below

**If yes,**

b) how often do you use it to make calls?

at least once a day   
4-6 times a week   
1-3 times a week   
less than once a week

c) how often do people ring you on it?

at least once a day   
4-6 times a week   
1-3 times a week   
less than once a week

H2. How often during the day are you in a room or enclosed place where people are smoking?

	(i) weekdays	(ii) weekends
all the time	<input type="text" value="1"/>	<input type="text" value="1"/>
more than 5 hours	<input type="text" value="2"/>	<input type="text" value="2"/>
3-5 hours	<input type="text" value="3"/>	<input type="text" value="3"/>
1-2 hours	<input type="text" value="4"/>	<input type="text" value="4"/>
less than 1 hour	<input type="text" value="5"/>	<input type="text" value="5"/>
not at all	<input type="text" value="6"/>	<input type="text" value="6"/>

H3. Do you tend to collect static electricity and have shocks when you touch metal?

Yes a lot  Yes occasionally  No, not at all

**SECTION J:**

J1. This questionnaire was completed by:

**Yes**

a) child's biological mother

b) child's mother figure

c) someone else  
(please tick and describe)

.....

J2. Do you live in the same house as the study child?

Yes

No

J3. Please give the date on which you completed this questionnaire:

day

month

year

J4. Please give your date of birth:

day

month

year

J5. Please give your study child's date of birth:

day

month

year

**THANK YOU VERY MUCH FOR YOUR HELP**

Space for any additional comments you would like to make

**NB Please remember we cannot reply to any comment unless you sign it.**

When completed, please return the questionnaire to:

**Professor Jean Golding  
Children of the Nineties - ALSPAC  
Institute of Child Health  
24 Tyndall Avenue  
Bristol BS8 1BR Tel: Bristol 928 8793**

For office use only  
*Coder* *Int*

© University of Bristol